TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

MFDR Tracking Number
M4-15-3428-01

MFDR Date Received
June 15, 2015

Respondent Name
WEST AMERICAN INSURANCE CO

Carrier's Austin Representative
Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient has authorization for 10 visits of physical therapy. Visits 1-3 were paid and also visits 5-7 were paid in full. Carrier shall not withdraw a preauthorization or concurrent review approval once issued. All other claims have been paid in full with o discrepancies. All of this documentation was sent in for reconsideration to the carrier… therefore, these claims should be paid in full."

Amount in Dispute: $1,188.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 12, 2014 through November 18, 2014	97140 x 3, 97112 x 3 and 97110 x 3	$1,188.42	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

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   -
   -

Issues

1. Did the requestor submit documentation to support that preauthorization was obtained for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning; (iii) Orthotics/Prosthetics Management; (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code..."

   Review of the submitted documentation contains insufficient information to support that preauthorization was obtained by the requestor for the disputed services rendered on November 12, 2014 through November 18, 2014. The requestor did not include a copy of the preauthorization letter issued by the insurance carrier to support that the disputed services were preauthorized. As a result, reimbursement cannot be recommended for the disputed services.
2. Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that the disputed services were preauthorized. As a result, reimbursement cannot be recommended for the disputed services rendered on November 12, 2014 through November 18, 2014.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 9, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.